TRANSPORT INFORMATION CHECKLIST
FOR PERSONS ON INVOLUNTARY STATUS

Name of individual transported_____ DOB_____
Designated Agency_____ **Name of QMHP:** _____
Address Transported from: _____ **Address Transported to:** _____
Time and Date of LAST Assessment: _____**Time and Date of Transport**_____

Pursuant to 18 V.S.A. §7511, secure transport and escort shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. Secure transport shall only be used when an individual poses a risk of harm to self or others and a less restrictive alternative is clinically contra-indicated.

Observation period prior to transportation decision may be used but should NEVER delay transport. Individual and/or family preference will be considered and accommodated, if possible, for mode of transport.

Considerations in Determining Mode of Transportation:
(Additional space below for elaboration, if needed.)

1. What is the client's history of transport behavior? ❑ cooperative ❑unwilling ❑ triggering ❑ unknown?
2. Have the client's friends/family been consulted regarding transportation options? ❑ No ❑ Yes
3. Has the client been consulted regarding transportation options? ❑ No ❑ Yes
4. Is the client able to regulate his or her behavior? ❑ No ❑ Yes client approachable to discuss options? ❑ No ❑ Yes
5. Any adverse events in last 24 hours of which transporters ought to be aware? ❑ No ❑ Yes
6. Does client's mood seem stable and sustainable for the length of transport ordered? ❑ No ❑ Yes
7. If client was given PRN medication in the ED, have you discussed whether medical monitoring via ambulance would be necessary? ❑ No ❑ Yes

Other supporting reasons for mode of transport provided, OR please reference from above

Signatures REQUIRED on back: OVER►

Mode of Transportation RECOMMENDED by QMHP or ED STAFF:

Vehicle	**Accompaniment**	**Restraints**
❑ Private transport	❑ friend/family	❑ None
❑ Mental health van alternative	❑ mental health staff	❑ Metal
❑ Unmarked alternative escort	❑ support specialist	❑ Soft
❑ Ambulance	❑ sheriff in vehicle	
❑ Sheriff's cruiser	❑ Other: Peer, advocate etc	
❑ Other _____	_____	

Team Signatures

Sign:_____PRINT_____
❑Signature of Qualified Mental Health Professional/Designated Professional

Phone contact info (REQUIRED):_____

❑Signature of ED MD	❑Signature of receiving transport specialist
Please Print Name:_____	**Please Print Name**:_____

Signatures required if parties are involved in assessment of transport needs/outcomes.

► Provide this form (both sides) to: ❑Transporter or mental health transport specialist, *and* ❑DMH: Pamela Shover (fax 802-241-0100)

****Original will accompany emergency exam papers. QMHP will keep a copy of this form for their records****